PLAN OF CARE/COST COMPARISON BUDGET
CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED) WAIVER

State Form 51549 (2-04) / TS 0003
Approved by State Board of Accounts, 2004

* This agency is requesting the disclosure of your Social number in accordance with IC 4-1-8-1. Disclosure is **voluntary** and you will not be penalized for refusal.

The information in this document is confidential according to IC 16-39-2.

Name of recipient (*last, first, and middle*)		
Address (*number and street, city, state, ZIP code*)		
Date of birth (*month, day, year*)	Social Security number *	Medicaid number
LOC decision date (*month, day, year*)	LOC previous approval date (*month, day, year*)	LOC pending? ☐ Yes ☐ No
☐ Initial POC/CCB ☐ Quarterly POC/CCB ☐ Update POC/CCB ☐ Re-entry -- Previous termination date _____		
Medicaid eligibility date (*month, day, year*)	Parental income excluded? ☐ Yes ☐ No	

LIFE DOMAINS: STRENGTHS & NEEDS (*Describe the child's and/or family's/caretaker's problems, issues, and needs. Include strengths/assets which are relevant to meeting the needs.*)

LIFE DOMAINS	STRENGTHS	NEEDS
Home		
Community		
Financial/Economic		
Health		
Legal		
Leisure/Recreation		

LIFE DOMAINS	STRENGTHS	NEEDS
Vocational/Educational		
Socialization		
Other		

PRESENTING PROBLEM: (*Describe child's problem/needs prior to the plan of care*)

STATEMENT OF GOALS/OUTCOMES: (*Describe how the child will function when all objectives are met. Examples: Child (name) will have no evidence of suicidal thoughts or gestures. Child will attend full day of school without running away.*)

OUTCOME OBJECTIVES	SERVICE AND SUPPORT NEEDED	RESPONSIBLE PERSON	DURATION AND FREQUENCY	TOTAL UNITS
1.				
2.				
3.				
4.				
5.				
6.				

CRISIS PLAN:

POTENTIAL CRISIS	CHILD RESPONDS WELL TO:	ACTION STEPS
1.		
2.		
3.		

CRISIS PLAN: (*continued*)

PERSON RESPONSIBLE	SERVICE AND SUPPORT NEEDED	DURATION AND FREQUENCY
1.		
2.		
3.		

☐ I have reviewed the services contained in this plan and I choose to accept this plan and the services explained to me.

Signature of applicant/parent/guardian		Date (*month, day, year*)
Signature of representative	Relation	Date (*month, day, year*)
Signature of wraparound facilitator		Date (*month, day, year*)
Signature of DMHA waiver manager		Date (*month, day, year*)

A. HOME AND COMMUNITY-BASED CARE COST

1. Plan of Care Information

a. Wraparound Facilitation	(15 min) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
b. Family Support and Training	(15 min) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
c. Independent Living Skills	(hour) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
d. Respite Care Scheduled Hourly	(15 min) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
e. Respite Foster Care Hourly	(15 min) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
f. Respite Care Crisis Hourly	(15 min) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
g. Respite Care Scheduled Day	(per diem) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
h. Respite Foster Care Day	(per diem) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	
i. Respite Care Crisis Day	(per diem) Units auth/mo		**X** Unit Cost	$	**=** Mo. Cost	$	

Total A.1. Waiver Service Cost	$
Total A.2. Other Medicaid Cost	$
Total A.5. Total HCBS Cost (*from page 6*)	$
Total B.5. Facility Cost Factor (*from page 6*)	$

2. Other Medicaid Services

a. Physician	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
b. Pharmacy	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
c. Therapy	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
d. Lab/X-Ray	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
e. Supplies	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
f. Durable Medical Equipment	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
g. Transportation	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$
h. MRO	3 month payment history	$	**÷ 3 =**	Estimated monthly Cost	$

2. Other Medicaid Services (*continued*)					
i. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
j. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
k. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
				Total A.2. - Other Medicaid Cost	$

3. Total of Lines	A.1.	$	+ A.2.	$	= $	A.3.
4. Minus Recipient Spend-Down Amount					- $	A.4.
5. Total Home and Community Care Costs					= $	A.5.

B. PSYCHIATRIC HOSPITAL COSTS

1. Hospital per diem	$	X 30 days	= $	B.1.

2. Other Medicaid Services					
a. Physician	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
b. Pharmacy	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
c. Lab/X-Ray	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
d. Transportation	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
e. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
f. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
g. Other	3 month payment history	$	÷ 3 =	Estimated monthly Cost	$
				Total B.2. Other Medicaid Cost	$

3. Total of Lines	B.1.	$	+ B.2.	$	= $	B.3.
4. Minus Recipient Liability Reduction					- $	B.4.
5. Total Psychiatric Hospital Cost					= $	B.5.

C. DOCUMENTATION OF PAYMENT HISTORY

(*Indicate sources and dates of information used to determine cost report in Section A.2.*)

D. DESCRIPTION

(*Describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the child. For updated Plan of Care , explain reason for change.*) (*Detail reasons for high cost*)

E. COST COMPARISON DETERMINATION

1. Cost Comparison Data Indicates;

a. If Line A.5. $_____ is equal to or less than B.5. $_____, the child is ELIGIBLE for Home and Community-Based Services the choice of hospital or community-based services must be offered.

☐ Recipient is ELIGIBLE for Home and Community Based Services.

b. If Line A.5. $_____ is greater than B.5. $_____, the child MAY NOT BE ELIGIBLE for Home and Community-Based Services.

☐ Child may not be eligible for Home and Community-Based Services

2. Request for Approval to Exceed Calculations

a. Monthly amount which exceeds hospital cost factor: $_____

b. Duration of excess costs: _____

Signature of Wraparound Facilitator	Date (*month, day, year*)

3. State Agency Determination to Exceed Cost ☐ Approved ☐ Denied ☐ NA

Authorized signature of Waiver Manager	Date (*month, day, year*)